APPENDIX 6
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR VISION SERVICES

ELEMENT 1 - PROCESSING TYPE
Enter the three-digit processing type 122 (vision).

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis of V53.1 cannot be used as the primary or sole diagnosis.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service/procedure/item requested, in this element.

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medical Assistance Program [WMAP] policy and the coding structure used) for each service/procedure/item requested.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 11 for allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. Refer to Appendix 11 for allowable type of service codes.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure/item requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).